STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DRIVE CARMEL, IN46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/31/11 and 06/01/11 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Carmel Health & Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial walkout lower level was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors,in all areas open to the corridors and in all resident rooms. The facility has	K0000	Submission of this plan of correction does not constitute admission of the cited deficiencies. Its submission is required by state and federal law governing health facilities. This plan does serve as an allegation of compliance as of the date indicated by each response.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	a capacity of 229 and had a census of 148 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/07/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0020 SS=E	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 2 of 2 vertical stairwell openings were enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.2 states the vertical opening shall be enclosed as appropriate for the fire resistance rating of the barrier. LSC 8.2.3.2.1 requires a one hour rated door in a one hour vertical opening. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-1.2 requires fire door assemblies to include latches. NFPA 80,	K0020	No residents were affected by the alleged deficient practice.Latching hardware that allows the doors to latch and close in the door frames has been installed on the stairway doors at the main entrance and by the speech therapy room.All stairway doors will be inspected to assure that latches are equipped.Maintenance supervisor/designee will audit all stairway doors and report to administrator/assistant administrator the findings. Latches will be installed as needed.Administrator/Assistant Administrator will review monthly for compliance for the next 12	07/01/2011

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	2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect any residents, staff and visitors in the vicinity of the stairwell door by the elevator in the main entrance and in the vicinity of the stairwell door by the speech therapy room. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 05/31/11, the stairwell door by the elevator in the main entrance and the stairwell door by the speech therapy room which each lead to the walkout lower level are equipped with magnetic locking devices and self closing devices but each stairwell door is not provided with latching hardware to allow the doors to latch and close in the door frames. Based on interview at the time of observation, the Director of Maintenance acknowledged each stairwell door is not provided with latching hardware to allow each door to latch into the door frame. 3.1-19(b)		months will all findings being forwarded to the Quality Assurance Commitee for review and further recommendations will be made as necessary.	

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K0027 SS=E	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 2 sets of smoke barrier doors in the corridor from the kitchen to the 700 South Hall would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect any resident, staff or visitor in the vicinity of the smoke barrier door set in the corridor from the kitchen to the 700 South Hall. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 05/31/11,	K0027	No residents were affected by the alleged deficient practice.The center hall smoke barrier door has been adjusted to to ensure that no more than a 1/8 inch gap is allowed between doors.All smoke barrier doors will be audited by maintenance supervisor/designee monthly to ensure that there is no more than a 1/8 inch gap upon closure. Administrator/Assist. Administrator will review monthly for compliance.The Administrator/Assistant Administrator will submit monthly finding for 12 months to the Quality AssuranceCommittee for review and further recommendations will be made as necessary.	07/01/2011

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	the doors of the center hall smoke barrier did not close completely, leaving a one and a half inch gap between the doors. Based on interview at the time of observation, the Director of Maintenance stated the door latching hardware was dragging on the floor and would not allow the door set to close completely and acknowledged a one and a half inch gap between the two doors when the doors were closed. 3.1-19(b)			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure 2 of 11 doors serving hazardous areas such as mechanical rooms with natural gas fired furnaces are equipped with self closing devices on the doors. This deficient practice could affect any resident, staff or	K0029	No residents were affected by the alleged deficient practice.Self closing devices have been installed on the door of the mechanical rooms by room 719 and room 404. A self closing device will be installed on the kitchen entry door. The 3 mechanical rooms with natural	07/01/2011

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	visitor in the vicinity of the mechanical room by Room # 719 and the mechanical room by Room # 404. Findings include: Based on observations with the Director of Maintenance during the tour of the facility from 1:00 p.m. to 3:15 p.m. on 05/31/11 and from 9:00 a.m. to 12:15 p.m. on 06/01/11, the mechanical room by Room # 719 and the mechanical room by Room # 404 each contain one natural gas fired furnace and are each not equipped with a self closing device on the entry door. Based on interview at the time of observation, the Director of Maintenance acknowledged the entry door to the mechanical room by Room # 719 and the entry door to the mechanical room by Room # 404 each are not equipped with a self closing device. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 doors serving hazardous areas such as the kitchen was equipped with an operable self closing device on the door. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen entry door in the corridor to the 700 South Hall.		gas fired furnaces will have positive latching mechanisms installed.All mechanical rooms containing a natural gas fired furnace will have doors inspected by maintenance staff to assure presence of a self closing device and positive latching mechanisms. The doors to the kitchen areas will also be inspected for presence of self latching devices. The findings of the inspection will be reviewed with the admininstrator/assistant administrator monthly.The administrator/assistant administrator will review monthly for 12 months for compliance with all findings being forwarded to the Quality Assurance Committee for review and further recommendations will be made as needed.	

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	Findings include: Based on observation with the Director of Maintenance during the tour of the facility from 1:00 p.m. to 3:15 p.m. on 05/31/11, the kitchen door is equipped with a self closing device on the entry door but the bottom hinge self closing device was disconnected from the door which allowed the entry door to be observed in the open position. Based on interview at the time observation, the Director of Maintenance acknowledged the door was not self closing with the hinge pin removed. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 3 of 11 hazardous areas such as mechanical rooms with natural gas fired furnaces are provided with positive latching mechanisms. This deficient practice could affect any resident, staff or visitor in the vicinity of the mechanical room by the elevator in the main entrance, in the mechanical room in 800 North, north of the nurses station, and in the vicinity of the mechanical room by room # 823. Findings include:			

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	Based on observations with the Director of Maintenance during the tour of the facility from 1:00 p.m. to 3:15 p.m. on 05/31/11 and from 9:00 a.m. to 12:15 p.m. on 06/01/11, the mechanical room by the elevator in the main entrance, the mechanical room in 800 North, north of the nurses station, and the mechanical room by room # 823 each contain one natural gas fired furnace and each mechanical room entry door is provided with a self closing device but is not provided with positive latching hardware. Based on interview at the time of observation, the Director of Maintenance acknowledged each mechanical room entry door is not provided with positive latching hardware. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2			

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	Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on the second shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Fire/Emergency Training: TELS Logbook Documentation" with the Director of Maintenance from 9:30 a.m. to 12:15 p.m. on 05/31/11, there is no documentation of a fire drill being conducted on the second shift in the fourth quarter in 2010. Based on interview at the time of record review, the Director of Maintenance stated a fire drill was conducted on the second shift of the fourth quarter of 2010 but acknowledged there is no documentation of a second shift fourth quarter fire drill available for review. 3.1-19(b)	K0050	No residents were affected by the alleged deficient practice.The Maintenance Surpervisor will schedule a fire drill for the month by the first day of each month and inform the administrator of the date and the shift the drill is to be held.The Maintenance Supervisor/designee will ensure that all documentation relating to monthly facility fire drill will be submitted to the administrator/designee each month. The drills will be conducted on every shift at least once per quarter.The administrator will review monthly for compliance for the next 12 months will all findings being forwarded to the Quality Assurance Committee for review and further recommendations will be made as needed.	07/01/2011
K0067 SS=F	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the	K0067	No residents were affected by the alleged deficient practice.Life	07/01/2011

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	facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 175 of 175 rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all of the residents, staff and visitors. Findings include: Based on observation with the Director of Maintenance during the tour of the facility from 1:00 p.m. to 3:15 p.m. on 05/31/11 and from 9:00 a.m. to 12:15 p.m. on 06/01/11, all resident rooms and facility support offices were using the egress corridor as a return air system, however, based on interview with the Director of Maintenance during the tour, the facility has modified the HVAC (Heating, Ventilation, and Air Conditioning) system so activation of the fire alarm system stopped the supply air fans. Additionally, the supply air fans had duct detectors located downstream of the air filters which when activated, shut down the fans		Safety code waiver is being requested for this time. See submitted documentation for waiver request.	

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	operation. Finally, smoke dampers interconnected to the fire alarm system were located to prevent the transfer of smoke from one compartment to other smoke compartments. 3.1-19(b)			
K0068 SS=E	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 11 utility rooms containing natural gas fired furnaces was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could affect residents, staff and visitors in the vicinity of the the mechanical room by room 404 in the 400 Hall. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 9:30 a.m. to 12:15 p.m. on 06/01/11, the mechanical room by Room 400 in the 400 Hall contains one natural gas fired	K0068	No residents were affected by the alleged deficient practice.A fresh air intake unit will be installed in the utility room on 400 hall.Maintenance staff will inspect all utility rooms with natural gas fired furnaces for the presence of intake combustion air from the outside.Administrator/Assistant Administrator will review monthly for compliance for 12 months. The findings will be forwarded to the Quality Assurance Committee for review and further recommendatiojns will be made as needed.	07/01/2011

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	furnace and is not provided with combustion air intake from the outside. Based on interview at the time of observation, the Director of Maintenance acknowledged there is no combustion air intake from the outside supplied to the mechanical room by Room 404 in the 400 Hall. 3.1-19(b)			
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire	K0143	No residents were affected by the alleged deficient practice.The self closing hinges on the one and a half hour rated door on the oxygen store room will be replaced.All doors requiring self closing devices will be inspected monthly for proper operation by	07/01/2011

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	resistive construction. This deficient practice could affect residents, staff and visitors in the vicinity of the 300 Hall oxygen storage and transfilling room. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 9:00 a.m. to 12:15 p.m. on 06/01/11, the 300 Hall oxygen storage and transfilling room door is a 45 minute rated door and is equipped with self closing hinge devices and latching hardware but the self closing device was rendered inoperable as the top hinge pin was removed. The door did not self close and was observed in the open position. Based on interview at the time of observation, the Director of Maintenance acknowledged the oxygen storage and transfilling room door self closing device top hinge pin was removed and the door did not self close and latch into the door frame. 3.1-19(b)		the maintenance staff.The Administrator/Assistant Administrator will review monthly for compliance for the next 12 months. The findings will be forwarded to the Quality Assurance Committee for review and further recommendations will be made as needed.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.			

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	1. Based on record review and interview, the facility failed to document the load percentage for the monthly load test for 3 of 3 emergency generators for 7 of 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "TELS: Generator I, II, III" documentation with the Director of Maintenance from 9:30 a.m. to 12:15 p.m. on 05/31, monthly generator load testing documented for the seven month period from 11/19/10 through 05/23/11 for each	K0144	No residents were affected by the alleged deficient practice.Readings will now be recorded as a percentage of the amp load not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating. The generator has been adjusted to transfer to the emergency generator within 10 seconds of building power loss.The maintenance department will ensure that all documentation relating to load testing is completed weekly. Maintenance supervisor will log the time it takes to transfer emergency generator power.The Administrator/Assistant Adminitrator will review logs monthly for 12 months. Findings will be reported to the Quality Assurance Committee for review and further recommendations will be made as needed.	07/01/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of three facility emergency generators show each emergency generator ran for at least thirty minutes during each documented load test but the minimum exhaust gas temperature was not recorded and the percentage of load capacity was recorded as the sum of the recorded amps for each phase of the three phases for each emergency generator. Based on interview at the time of record review, the Director of Maintenance acknowledged the facility did not document the percentage of load capacity for each generator on each of the stated load test dates and acknowledged the minimum exhaust gas temperature was not recorded on each of the stated load test dates. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 2 of 12 months for 1 of 3 facility emergency generators. NFPA 99, 3-4.1.1.8 states generator sets shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	06/01/2011

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	repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "TELS: Generator I, II, III" documentation with the Director of Maintenance from 9:30 a.m. to 12:15 p.m. on 05/31/11, weekly load test documentation for the two month period from 04/12/11 to 5/23/11 lists the transfer time as 32 to 37 seconds for emergency generator II. Based on interview at the time of record review, the Director of Maintenance stated the transfer time to transfer power to emergency generator II for weekly load testing in April and May 2011 was timed and recorded as between 32 and 37 seconds and acknowledged the transfer time was greater than 10 seconds. 3.1-19(b)			